CHAMPVA POLICY MANUAL

CHAPTER: 3
SECTION: 6.2
TITLE: HOSPITAL REIMBURSEMENT - CHAMPVA DRG-BASED PAYMENT SYSTEM

AUTHORITY: 38 CFR 17.270(a), 17.272(b) and 17.274

RELATED REFERENCES: 42 CFR parts 489 and 1003; 32 CFR 199.14(a)(1)

I. EFFECTIVE DATE

Implementation of the CHAMPVA DRG-based payment system was effective for admissions on or after October 1, 1987. Unless specified differently in the proceeding sections of this policy, this date is to be considered the effective date for the DRG system.

II. DESCRIPTION

A. CHAMPVA uses the same diagnosis related group (DRG) based prospective payment system (PPS) used by TRICARE.

B. 42 CFR parts 489 and 1003 reference that hospitals participating in Medicare must also accept the CHAMPVA determined allowable amount for inpatient services as payment-in-full.

C. This reimbursement system is modeled on Medicare's prospective payment system (PPS) and applies only to hospitals. Although many of the procedures in the CHAMPVA DRG-based payment system are similar or identical to Medicare, the actual payment amounts, in some cases, are different. This is because the Medicare program is designed for a beneficiary population over the age of 65, while CHAMPVA primarily serves beneficiaries under the age of 65 who are considerably younger and generally healthier. For example, services such as obstetrics and pediatrics are rare for Medicare.

III. POLICY

A. Applicability of the DRG-based system.

1. Areas affected. The DRG-based payments system applies to hospital inpatient services in the fifty states, the District of Columbia, and Puerto Rico.

2. State waivers. Any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs of inpatient services, may be exempt from the CHAMPVA DRG-based payment system. The state must be exempt from the Medicare Prospective Payment System (PPS). The only state currently exempt is Maryland. Inpatient services provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since Maryland hospitals are required to bill these rates, CHAMPVA reimbursement for inpatient services are to be based on the billed charge. CHAMPVA payment under such system must continue to be at a level to maintain savings comparable to those that would be achieved under the CHAMPVA DRG-based payment system. Reimbursement for outpatient and inpatient professional services will be based on the CHAMPVA maximum allowable charge (CMAC) (see Chapter 3, Section 5.1, *Outpatient and Inpatient Professional Provider Reimbursement).*

B. Assignment of Discharges to DRGs.

1. The classification of a particular discharge is based on the patient's age, sex, principal diagnosis, secondary diagnoses, procedures performed, and discharge status.

2. Under the DRG-based payment system, payment for the operating costs of inpatient hospital services is made on the basis of prospectively determined rates and applied to the DRG value at the time of discharge or transfer. Capital related costs and direct medical education costs are not included in the base DRG rates nor in adjustments made for transfer or outlier situations. These adjustments are made by multiplying the base DRG value and any adjustments for outliers, i.e., hospital education factor. The result of this computation is the DRG value and the CHAMPVA allowed amount for that period of hospitalization.

3. Each discharge, transfer or death will be assigned to only one DRG regardless of the number of conditions treated during the patient's stay. In some cases the admitting diagnosis may be different from the principal diagnosis. It is the hospital's responsibility to submit the information necessary for assignment of a discharge to a DRG.

IV. POLICY CONSIDERATIONS

A. The following data is necessary to assign the appropriate DRG to inpatient claims. This information is updated annually and submitted to CHAMPVA by the TRICARE data contractor to be incorporated into CHAMPVA payment calculations.

1. DRG weighting factors,

2. Adjusted Standardized Amounts (ASA) urban and rural, including the labor-related and nonlabor-related portions,

3. area wage indexes,

4. outlier cutoffs for each DRG,

5. children's hospital outlier cutoffs,

6. arithmetic mean length-of-stay for each DRG,
7. beneficiary per diem cost shares, and

8. children's hospital differentials (national and hospital-specific).

Note: References to the DRG-based calculation process and associated factors are found within TRICARE Reimbursement Manual, Chapter 6, Section 5, *Determination of Payment Amounts*; Section 6, *DRG Weighting Factors*; Section 7, *Adjusted Standardized Amounts*; and Section 8, *Adjustments to Payment Amounts.*

B. Capital and medical education costs. An adjustment factor of 12% is added to the base DRG rate.

C. Hospital billing. Under the CHAMPVA DRG-based payment system, hospitals are required to submit claims to include itemized charges.

D. Late Charges. In accordance with Chapter 3, Section 5.8, *Penalty Charges for Late Payment*, no additional payment will be made for late charges.

E. Beneficiary submitted claims. All inpatient and CITI claims will be paid to the provider regardless of whether the beneficiary specifically requests payment. If a beneficiary submits a claim that is subject to the DRG-based payment system, whether for inpatient services or for related professional services rendered by a hospital-based provider, the claim will be processed with payment made to the provider.

F. Payment on a per discharge basis. Under the DRG-based payment system, hospitals are paid on a predetermined amount per discharge for inpatient hospital services.

G. Claims priced as date of discharge. All claims reimbursed under the DRG-based payment system are priced as of the date of discharge using the rules, weights and rates in effect on the date of discharge.

H. Inpatient care spanning two calendar years. When the dates of inpatient care span different calendar years, the cost share will be credited toward the catastrophic cap for the year in which the beneficiary was discharged.

I. Payment in full. The DRG-based amount paid for inpatient hospital services is the full payment for the inpatient operating costs incurred in furnishing the services of the covered benefit. The full prospective payment is payable for each stay during which there is at least one covered day (in excess of 24 hours) of care. Exception to this rule is provided in paragraph M. 3. for short-stay outliers. Certain items related or incidental to the treatment of the patient, but which might not otherwise be covered, are included in the DRG-based system. For example, patient education services are not covered benefits, but if they are provided incidental to covered services, they are to be considered included in the DRG-based payment. The hospital cannot bill the beneficiary for the services since they are included in the overall treatment regimen.

1. Services received from another hospital. In those cases where the hospital obtains certain services from another hospital, no additional payments are to be made to either hospital for the technical component of the services. Such service is considered part of the DRG-based payment system and it is the discharging hospital's responsibility to make payment arrangements with the other hospital providing services. The professional component of these services must be billed separately by the second hospital.

2. Interim bills. Because the DRG-based payment is the full payment for the claim, interim bills will not be accepted.

J. Emergency room with subsequent inpatient hospital admission. If the beneficiary was admitted to the hospital as an inpatient through the emergency room, the entire episode of care will be billed under the DRG. The emergency room services cannot be billed separately.

K. Inpatient operating costs. The DRG-based payment system provides a payment amount for inpatient operating costs which includes:

1. routine services, such as the room cost, board, therapy services, and routine nursing services, as well as supplies necessary for the treatment of the patient,

2. ancillary services, such as radiology and laboratory services (the professional component of these services is not included and can be billed separately),

3. take home drugs,

4. special care unit operating costs, and

5. malpractice insurance costs.

L. Discharges and Transfers.

1. Discharges. A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

a. the patient is formally released from the hospital, or

b. the patient dies in the hospital, or

c. the patient is transferred to a hospital or unit that is excluded from the DRG-based payment system, i.e., transferred from a surgical unit of a DRG-based hospital to a psychiatric unit within the same hospital. Such instances will result in two or more claims.

2. Transfers.

a. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment if the discharge is made from a hospital included under the DRG-based payment system to the care of another hospital that is:

(1) paid under the DRG-based payment system and in such instances, the result will be that two (or more) claims will be generated and the claims will be subject to two separate cost shares, or

(2) exempt from being paid under the DRG-based payment system because of participation in a statewide cost control program or to a hospital or distinct hospital unit excluded from the DRG-based payment system as described in Chapter 3, Section 6.3, *Cost-To-Charge (CTC) Payment System. S*uch instances will result in two or more claims.

b. Transfers from one inpatient area or unit of a DRG-based hospital to another inpatient area or unit of the same hospital will result in a single claim.

M. Leave of Absence Days.

1. Normally, a patient will leave a hospital only as a result of a discharge or a transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled immediately, additional

testing which is not available at that particular time, or a change in the patient's condition.

2. Billing for leave of absence days. In billing for inpatient stays, which include a leave of absence, hospitals are to use the actual admission and discharge dates and are to identify all leave of absence days. Leave of absence days are disallowed and neither CHAMPVA nor the beneficiary may be billed for days of leave.

3. DRG-based payments for stays including leave of absence days. Placing a patient on a leave of absence will not result in two DRG-based payments. Only one claim is to be submitted when the patient is formally discharged (as opposed to being placed on leave of absence) and only one DRG based payment is to be made. The leave of absence does not increase the beneficiary's cost share.

4. Services received while on leave of absence. The technical component of laboratory tests obtained while on a leave of absence is included in the DRG-based payment to the hospital. The professional component is cost shared as inpatient. Tests performed in a physician's office or independent laboratory are also included in the DRG-based payment.

5. Patient dies while on leave of absence. If a patient should die while on leave of absence, the date the patient left the hospital shall be treated as the date of discharge.

N. Outlier Adjustment.

1. The DRG-based value is adjusted for atypical cases. These cases include outliers that have either an unusually short length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG.

2. Payment of outliers. For all admissions occurring before October 1, 1998, if the claim qualifies as both a length-of-stay outlier and a cost outlier, payment shall be based on the length-of-stay (LOS) outlier. For admissions occurring on or after October 1, 1988, claims which qualify as both a LOS outlier and a cost outlier shall be paid at whichever outlier calculation results in the greater payment. A claim will not receive both a LOS outlier and a cost outlier adjustment.

3. Short-stay outliers. Any discharge with LOS less than or equal to the greater of 1 or 1.94 standard deviation from the DRG's arithmetic LOS shall be classified as a short-stay outlier. Short-stay outliers will be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. Any stay, which qualifies as a short-stay

outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be reported on the payment records as a short-stay outlier.

4. Long-stay outliers. All long-stay outliers have been eliminated.

O. Beneficiary Eligibility.

1. Loss of eligibility. When a beneficiary loses eligibility while hospitalized for a covered service, the following policy applies:

a. If the beneficiary is a patient in a DRG hospital, the full DRG rate for the hospital stay, including payment for any cost outlier situation, will be paid.

b. If the beneficiary is a patient in a DRG hospital and loses eligibility while in a day-outlier situation, the full DRG rate plus the outlier per diem rate for the outlier days during which the beneficiary had eligibility will be paid.

2. Gain of eligibility. If a beneficiary becomes eligible while hospitalized for a covered service, the full DRG rate for the entire episode of care including payment of any applicable outlier situations will be paid.

3. Payment when eligibility changes. Except for those claims that qualify as day outliers, if a beneficiary is eligible for coverage during any part of his/her inpatient stay, the claim shall be processed as if the beneficiary was eligible for the entire stay. This applies whether or not the beneficiary loses or gains eligibility during the stay. However, if the loss of eligibility results from gaining Medicare eligibility, the claim may still be processed, but it must be submitted to Medicare first and payment will be determined under the normal double coverage procedures.

P. Beneficiary Liability.

1. Inpatient cost sharing. A separate cost sharing amount is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose (medical or surgical), regardless of the number of times a beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related condition.

Note: All admissions related to a single maternity episode should be considered one stay, regardless of the number of days between admissions.

2. Services subject to the DRG-based payment system. For services and supplies based on the prospective payment system, the beneficiary liability cost share is the lesser of:

a. the per diem times the number of inpatient days, or

b. 25% of the billed amount, or

c. the base DRG amount.

Note: The cost share is never to exceed the base DRG amount. In establishing the beneficiary cost share, the base DRG will not include the education factor or the cost/stay outlier adjustment as applicable. In addition, when the annual catastrophic cap of $3,000 is met for the CHAMPVA-eligible family, the cost share for covered services for the remainder of the calendar is waived with CHAMPVA paying 100% of the allowable amount.

3. Cost sharing is waived for inpatient services provided by a VAMC under the CHAMPVA In-house Treatment Initiative (CITI) program.

4. Deductible liabilities for inpatient hospital services. There is no deductible requirement for inpatient hospital services, including professional service (see Chapter 3, Section 2.2, *Deductible).*

5. Beneficiary liability for non-covered DRGs. When the DRG is not covered, the claim will be denied. Payment of such claims will be the responsibility of the beneficiary.

6. Services and supplies not related to the treatment regimen. Charges for services and supplies specifically excluded from payment and which are not related to the treatment regimen (e.g., private room, television/telephone charges) are the responsibility of the beneficiary.

7. Medically unnecessary days are the beneficiary's responsibility. If medically unnecessary days of care are provided because the beneficiary insisted on remaining in the hospital even though the hospital/physician attempted to discharge, any charges for those days are the responsibility of the beneficiary.

Q. Inpatient professional billing criteria are found within Chapter 3, Section 5.1, *Outpatient and Inpatient Professional Provider Reimbursement.*

R. Other Health Insurance (OHI).

1. With the exception of Medicaid, supplemental and indemnity policies, or State Victims of Crime Compensation Programs, CHAMPVA is

always the secondary payer of health care benefits when other health insurance exists. Beneficiaries do not have the option of waiving benefits of another plan or program in order to place CHAMPVA as the primary payer position.

2. If there is OHI, the CHAMPVA payment will be determined in accordance with the procedures outlined within Chapter 3, Section 4.1, *Other Health Insurance (OHI)*.

Note: Under no circumstances will the CHAMPVA payment exceed the CHAMPVA allowable amount or the billed amount which ever is less.

END OF POLICY